

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

11874-63-045340  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

318 1003  
FILED DEC 5 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis	
Length of stay in lb 3 wks		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 8511 Vulcan	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Vera Lommen Cox			4. DATE OF DEATH Month Day Year Dec. 1 1963		
5. SEX Feamle	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Mar. 18, 1892	9. AGE (last birthday) 71	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Telephone		11. BIRTHPLACE (City and state or country) Scott Co. Ill.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME James Webster			
13b. MOTHER'S MAIDEN NAME Harriet Roberts		14. NAME OF HUSBAND OR WIFE Fred deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. [redacted]		17. INFORMANT Thessel Shepard 5235 Windsor Parkway	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic C.V. disease</u> DUE TO (c) <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female, was there a pregnancy in last 90 days? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>10-25-63</u> to <u>12-1-63</u> and last saw her alive on <u>12-1-63</u> Death occurred at <u>1:15</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Bert H. Klein</u> (Degree or title)		22b. ADDRESS <u>2632 S. KING HIGHWAY</u>	
22c. DATE SIGNED <u>12-2-63</u>		23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>	
23b. DATE <u>12/4/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Concord</u>		23e. LOCATION (City, town, or county) <u>Ill.</u>	
24. FUNERAL DIRECTOR <u>John L. Ziegenhein &amp; Sons 7027 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 2 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Ed Smith, M.D.</u>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

E. P. K. K. K.

Licensed Embalmer No.

3877

P. O. Address

7027 H. H. H.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.